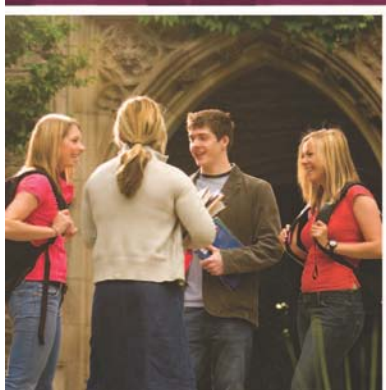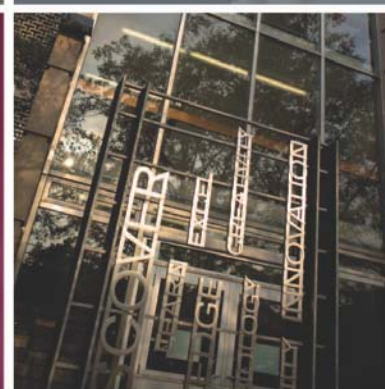McMaster University

DIALOGUE SUMMARY

# EXPANDING THE UPTAKE OF HOSPITAL-BASED TOBACCO-USE CESSATION SUPPORTS ACROSS ONTARIO

18 JANUARY 2012

**EVIDENCE >> INSIGHT >> ACTION**

**Dialogue Summary:**
**Expanding the Uptake of Hospital-based Tobacco-use Cessation Supports Across Ontario**

18 January 2012

Evidence >> Insight >> Action

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

Authors

John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor, McMaster University

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# SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed that Ontario hospitals lack a common, feasible, cost-effective and sustainable approach to delivering tobacco-use cessation supports. They attributed the lack of a common approach to factors operating at the individual level among hospital executives and staff (e.g., lack of awareness and commitment), and at the system level (e.g., lack of agreed hospital practices that are supported by the best available data and research evidence and that are scalable to local contexts, as well as a lack of a systematic, province-wide effort to support the adoption of these agreed practices). Dialogue participants also commented on the lack of measurement of existing practices, appropriate resourcing and accountability agreements.

Dialogue participants generally supported the following principles: 1) the goal for a 'population-based' tobacco-use cessation support initiative in Ontario hospitals should be 100% coverage of all tobacco users (even if an intensive 'clinical' response is targeted only at select patients); 2) the elements of such an initiative should be based on leading practices as determined by an expert group with experience in administering such hospital-based programs and in related domains, but with a focus on describing incremental or scalable enhancements (or packages of or options for enhancements) that can be flexibly introduced by each Ontario hospital as it moves from wherever it currently is towards full implementation; and 3) the system-wide roll-out of such an initiative should begin with the measurement of existing practices, then move to appropriate resourcing, and finally move to clear accountability agreements. In order to inform the process for documenting leading practices, dialogue participants deliberated about the following six questions: 1) what is the ideal process? 2) who should do what? 3) what resources would be needed? 4) what are the indicators for success?; 5) what reminder systems are needed to ensure this is done?; and 6) who do you hold accountable to do this?

A number of dialogue participants argued that one key set of next steps – the development of a performance-management model to support organizational change – would ideally come in a sequenced way from the Ontario Ministry of Health and Long-Term Care, which could: 1) issue a directive about the need to develop a small set of indicators that would be tracked across all Ontario hospitals; 2) request Local Health Integration Networks to add to hospital global budgets a budget line that provides the necessary resources for each hospital to provide the tobacco-use cessation supports that indicators suggest there is a need for; and 3) request Local Health Integration Networks to add to accountability agreements with hospitals what is expected in return for these dedicated funds (as well as add to accountability agreements with community-based clinics what is expected of them). Dialogue participants also argued that a complementary set of next steps could be undertaken by Health Quality Ontario (e.g., convening the proposed expert panel and supporting the system-wide roll-out of the enhancements), as well as by a number of other provincial and national organizations.

# SUMMARIES OF THE FOUR DELIBERATIONS

## DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed that Ontario hospitals lack a common, feasible, cost-effective and sustainable approach to delivering tobacco-use cessation supports.

Several dialogue participants attributed the lack of a common approach to factors operating at the individual level. These factors included the lack of awareness of and a lack of commitment to and prioritization of tobacco-use cessation support by hospital executives and staff, which one dialogue participant called 'ignorance and indifference'. Another dialogue participant noted that hospital-based tobacco-use cessation was 'not on the radar screen as a critical issue', and there was none of the needed awareness that 'if we do this, we could make a difference.' A third dialogue participant lamented the 'lack of a CEO table' where a few champions (such as those that exist in Thunder Bay and in select other communities) could raise awareness about the problem and practical solutions to addressing it, and garner commitment to implement these solutions. A fourth dialogue participant emphasized the importance of documenting how tobacco-use cessation support benefits patients in order to win over hospital staff. A fifth dialogue participant reminded others that there are hospital staff who are using the Registered Nurses Association of Ontario 'best practice guideline' and the Ontario Medical Association's standard, and that such success stories should be acknowledged.

A number of dialogue participants attributed the lack of a common approach to factors operating at the system level. Dialogue participants were asked which of the following options they considered to be a helpful way of framing the system-level problem:
1) lack of a common standard for hospitals that is widely agreed upon;
2) lack of implementation of a common standard, which in the view of one dialogue participant is the guideline published by the U.S. Department of Health and Human Services in 2008;
3) lack of documented 'best' or 'leading' practices in six areas (for simplicity, the term 'leading' practice will be used throughout the rest of the dialogue summary); and/or

**Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:
1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

4) lack of a systematic scaling up of leading practices to achieve 100% coverage across Ontario (and reliance on a small number of champions where successes have been achieved).

Dialogue participants differed in whether they preferred the language of common standard (option 1) or 'leading' practice (option 3), but most agreed that a significant contributor to the problem was the lack of agreed hospital practices that are supported by the best available data and research evidence, and that are scalable to local contexts (e.g., hospitals and units within hospitals; little in place versus very advanced). On the subject of scalability, one dialogue participant argued that 'one-size-fits-all is not a strategy', and another argued that options for standards are needed, 'not a standardized approach.' A third dialogue participant agreed that what's lacking is a common approach that is 'effective, efficient and flexible.' Dialogue participants also differed in whether they preferred the language of implementation (option 2) or scaling up (option 4), but most agreed that there is a lack of a systematic, province-wide effort to support the adoption of agreed hospital practices. One dialogue participant argued that any systematic support effort needed to align with existing hospital practices (e.g., how physicians arrange for follow-up) and with existing types of programmatic responsibilities that hospitals already have. The same individual argued that any systematic support effort needed to work within a model of supporting organizational change, such as a performance-management model or a systems-learning model. Several dialogue participants noted that whether one focused on the lack of implementation of a common standard or the lack of systematic scaling up of leading practices, large hospitals often posed greater challenges than small hospitals.

Dialogue participants also commented on the lack of measurement of existing practices, appropriate resourcing and accountability agreements, all of which were noted by one individual to be elements of a performance management model for supporting organizational change. One dialogue participant commented specifically on the lack of measurement and noted that we do see action when key areas of performance are measured and publicly reported, as they are in the cancer care system. A few dialogue participants noted that the findings from the one-off Ontario Tobacco Research Unit survey about current hospital practices (which in their view suggested much higher levels of tobacco-use cessation support than actually is the case) reinforce the importance of having a rigorous, sustained measurement system in place. Several dialogue participants lamented the lack of resources to support tobacco-use cessation. One participant commented that 'if you don't fund it, it won't happen.' A number of dialogue participants also identified the lack of accountability for supporting tobacco-use cessation in hospitals. One participant noted that hospital executives and staff think of themselves as responsible for treatment but not prevention. This individual observed that many hospital staff view tobacco-use cessation as a public health responsibility, and not as the shared responsibility of hospitals (both their staff, including physicians, and the organizations themselves), community-based providers and organizations, and public health practitioners and units. Two dialogue participants noted that there are examples of widespread agreement about areas of shared responsibility, such as identifying and supporting patients with high blood pressure and supporting the initiation and continuation of breast feeding, which can be drawn on as examples of how things can be done. A fourth dialogue participant argued that hospital executives do what's expected of them so action in this domain hinges on tobacco-use cessation support being clearly identified as a ministry priority, and built into accountability agreements with Local Health Integration Networks. However, a fifth dialogue participant worried aloud that system-wide accountabilities needed to be established for action (including the necessary post-discharge follow-up) to happen.

Several dialogue participants concluded their observations about the problem by noting that a systems approach would be critical to success, but that individuals would still need to be 'won over' to the view that supporting tobacco-use cessation was the right thing to do for their patients (and in the words of one participant, that 'anything less is substandard practice').

## DELIBERATION ABOUT THE ELEMENTS OF A COMPREHENSIVE APPROACH

Dialogue participants generally supported the following principles:
1) the goal for a 'population-based' tobacco-use cessation support initiative in Ontario hospitals should be 100% coverage of all tobacco users (even if an intensive 'clinical' response, which one dialogue participant likened to a SWAT team, is targeted only at select patients);
2) the elements of such an initiative should be based on leading practices as determined by an expert group with experience in administering such hospital-based programs and in related domains (e.g., a local initiative in Hamilton, a regional initiative in northwestern Ontario, and a provincial network using the Ottawa Model for Smoking Cessation), but with a focus on describing incremental or scalable enhancements (or packages of or options for enhancements) that can be flexibly introduced by each Ontario hospital as it moves from wherever it currently is (e.g., a focus on supporting tobacco-use cessation among patients being admitted for elective surgery or for the treatment of two or more chronic diseases, and using a simple identify/assist/refer approach) towards full implementation; and
3) the system-wide roll-out of such an initiative should begin with the measurement of existing practices, then move to appropriate resourcing, and finally move to clear accountability agreements.

Several dialogue participants noted that the first principle – aiming for a population-based initiative – can either be built incrementally from an intensive clinical response or be complemented by this type of intensive clinical response. One dialogue participant noted that many of the hospitalized tobacco users in the participant's region are young men who have been admitted due to injuries, and young women who have been admitted for labour and delivery, both groups of whom could 're-capture' many of the 'potential years of life' they will otherwise lose if they don't quit using tobacco. This individual also noted the protective effects that accrue to family members in these young people's homes with one less tobacco user present. A second dialogue participant argued that in at least some hospitals the intensive 'clinical' response is what's being provided (albeit not consistently) and the 'population-based' approach is what's lacking, while a third observed that the same could be said for alcohol use. A fourth dialogue participant asked whether 'stage-of-change' data could be used to target the intensive 'clinical' response, however, a fifth argued that such data have not proved helpful.

A few dialogue participants noted that the rationale for the second principle is that many insights about what actually works (based on rigorous monitoring and evaluation in Ontario test sites) and about the practicalities associated with providing tobacco-use cessation supports, need to be captured when crafting the leading practices that would be the focus of system-wide roll-out. One dialogue participant noted that an additional rationale for this approach is that the search for studies included in the widely used guideline on the topic (published in 2008) was conducted 4.5 years ago (in June 2007) and in clinically focused databases (where research about organization- and system-level interventions may not be published). Several dialogue participants disagreed about whether to restrict the expert group only to those with experience in administering hospital-based tobacco-use cessation programs, or whether to expand it to include those with experience in developing or selecting indicators, administering performance-measurement systems, and supporting organizational change. One dialogue participant cautioned against a broad-based group that would support 'regression to the mean' (i.e., focusing on a low standard rather than identifying pathways to a very high standard).

Regarding the third principle, one dialogue participant noted that Cancer Care Ontario is a good example of a central agency that uses a sequenced combination of measurement, resourcing and both accountability agreements and public reporting to support system-wide roll-outs. This participant argued that without measurement, resourcing couldn't be targeted based on needs, and that without resourcing, accountability couldn't be demanded. Another dialogue participant agreed that such a performance-management model was needed to move us beyond the existing situation of Ontario being a province of pilot projects in this domain

(which, the individual pointed out, is in keeping with Canada being known as the country of pilot projects, but is not an optimal situation).

In order to inform the process for documenting leading practices in hospital-based tobacco-use cessation support, dialogue participants deliberated about the following six questions (instead of the three elements of a comprehensive approach to addressing the problem, which was how the research evidence was presented in the evidence brief):
1) what is the ideal process?
2) who should do what?
3) what resources would be needed?
4) what are the indicators for success?
5) what reminder systems are needed to ensure this is done? and
6) who do you hold accountable to do this?
The deliberations were informed by one dialogue participant's pre-circulated response to each of these questions. One dialogue participant reminded the group that deliberating about these points was helpful, but that the expert group would need to review these question and the provisional answers in light of robust data and research evidence.

## Question 1 – What is the ideal process?

Dialogue participants discussed a number of elements of an ideal process for supporting tobacco-use cessation in hospitals, including how tobacco users should be identified and documented, what assistance needs to be provided to tobacco users, what follow-up is needed, and what policies and procedures are needed.

Beginning with how tobacco users should be identified and documented, several dialogue participants argued for having this done at admission (or registration for an outpatient visit) directly into the electronic admitting (or registration) record by admitting (or registration) staff. One dialogue participant gave the example of '30-day point prevalence' as an example of the type of question that can be asked with forced-choice answer options and a 'no bypass' option. Two dialogue participants argued that a 'no bypass' option wasn't practical given the number of non-elective hospital admissions where tobacco use cannot be determined (e.g., with unconscious patients). One dialogue participant suggested adding a tobacco-use question to healthcare provider assessments (e.g., a history and physical examination form), which can then prompt the healthcare provider to order one or more interventions and to initiate the use of an intervention-tracking form. Another dialogue participant argued for identifying and documenting tobacco use before admissions for elective procedures.

Turning to what assistance needs to be provided to tobacco users, a number of dialogue participants argued in favour of a combination of counselling and pharmacotherapy. For counselling, one dialogue participant noted that the 2008 guideline recommended a minimum of one to three minutes of 'intervention' following the '5A' protocol (i.e., ask patients if they use tobacco, advise them to quit, assess readiness to quit, assist with quitting, and arrange follow-up), but preferably eight or more sessions of 10 or more minutes each, for a total of 90-300 minutes. However, one dialogue participant argued that while the one to three minutes of counselling might be practical, the 90+ minutes 'is a non-starter' in most if not all Ontario hospitals. The same individual argued that any population-based strategy would need to do a much better job of taking resource constraints into account. A second dialogue participant agreed, noting that 'beyond a certain amount [of counselling], results are not great.' A third dialogue participant also agreed, suggesting that the key question is what minimum standard is feasible given the resources likely to be available. Dialogue participants noted that the issue of the optimal combination of pharmacotherapies (e.g., a combination of nicotine-replacement therapy and bupropion as recommended in the 2008 guideline) would best be addressed by an expert group.

Dialogue participants did not offer many comments about the specifics of when assistance should be provided in the course of a hospital stay or visit, what follow-up is needed (including by whom, when and for how long), and what policies and procedures need to be developed or adapted. While recognizing that these points could be addressed by an expert group, one dialogue participant argued that: 1) assistance should be provided as soon as patients are stabilized; 2) post-discharge follow-up should continue for at least one month (which often can best be accomplished through referral to the Smokers' Helpline or a community-based clinic); 3) electronic admitting forms, history and physical forms, care pathways and drug formularies need to be adapted; and 4) intervention-tracking forms, standard-order forms, clinician-feedback forms and a 'policy and procedure' document need to be developed if they don't already exist. Another dialogue participant emphasized the importance of using a culturally sensitive approach in working through many of these issues in particular settings.

A number of dialogue participants commented on the challenges associated with finding a community-based clinic where patients can be referred. On the one hand, there are 30 Family Health Teams in the network using the Ottawa Model for Smoking Cessation, there are a number of Aboriginal Health Access Centres, Community Health Centres and Family Health Teams participating in the Smoking Treatment for Ontario Patients (STOP) program (and through which patients can obtain free nicotine-replacement therapy), and patients don't need to be a registered client with one of these three types of community-based clinics to access tobacco-use cessation support. However, on the other hand, the application process for community-based clinics to be designated part of the STOP program is very labour-intensive and most Ontarians do not obtain their primary healthcare through one of these three types of community-based clinics.

## Question 2 – Who should do what?

Dialogue participants generally supported the idea that hospital administrators are best positioned to identify which types of healthcare providers (e.g., nurses, psychologists or physicians) should be involved in supporting tobacco-use cessation in light of issues ranging from scope-of-practice and workload issues to collective agreements, while recognizing that it makes sense to delegate the identification and documentation of tobacco users at admission (or registration) to admitting (or registration) staff. One dialogue participant commented that 'I'm not so concerned by who should do what to whom' because 'we can train anyone as long as they can express their skills within [well organized] systems.' A second dialogue participant disagreed, arguing that knowing the 'who' is essential to identifying what resources are needed. This individual noted that nurses account for the majority of paid hospital staff and are with patients 24 hours a day, seven days a week, which makes them natural candidates for a role in tobacco-use cessation support. This individual also noted that 'a critical mass of champions' is needed regardless of who is paid to do this work. A third dialogue participant reminded others that counsellors can come from many backgrounds and not just from nursing backgrounds. A fourth dialogue participant reminded others how hospital staff are already stretched very thin so any requests being made of these staff had to fit into existing procedures and take very little time (e.g., standing orders). A fifth dialogue participant agreed, noting that while a local hospital had been named a Registered Nurses Association of Ontario (RNAO) 'best practice spotlight organization' for their work on tobacco-use cessation support, the hospital was not as successful as hospital executives and staff had hoped they would be, because frontline nurses were so overburdened. Very little was said during the dialogue about who should do what types of follow-up within the community, however, dialogue participants noted that counsellors at the Smokers' Helpline and nurse practitioners in community-based clinics can be among those who assume key follow-up roles (and that these community-based staff could be engaged to play a role within hospitals as well).

Dialogue participants did not offer many comments about what additional training might be required (and with what frequency of training) or whether there was a need for some form of certification or verification that a process is followed correctly, or incorporation into staff performance reviews. One dialogue participant

suggested that: 1) additional training could be provided through orientations for new staff and regular in-service training sessions; 2) neither certification nor performance reviews should be mandatory (given issues ranging from RNAO designating tobacco-use cessation support as a best practice for all registered nurses, to certification requiring resources to support it and creating challenges to 'back fill' shifts while nurses obtain it); and 3) intervention forms can be captured through quality-related chart audits, which is an existing performance-review mechanism. A second dialogue participant argued that a certain amount of awareness-raising was needed for all hospital executives and staff, but that more intensive training could be designed for the person fulfilling the central coordinator role (who receives the daily census of tobacco users, provides or oversees the delivery of tobacco-use support, and undertakes or oversees follow-up calls), and for those engaged in the more intensive 'clinical response' (and this individual noted that such a 'SWAT team' as it was called previously, would also help to raise the profile of the work throughout the hospital). A third dialogue participant noted that training could be provided through continuing medical education programs for physicians and through continuing professional education for other healthcare providers. A fourth dialogue participant mentioned how a short training program for security staff turned an unpleasant interaction – requesting that people smoke in designated areas outside hospitals or off the property entirely – into a teachable moment.

## Question 3 – What resources would be needed?

Several dialogue participants indicated that the most important types of resources needed are a hospital 'budget line' that includes the dollars needed to provide tobacco-use cessation support (i.e., counselling, pharmacotherapy such as nicotine-replacement therapy, and central coordination, as well as systems support for indicator tracking and possibly for a voice-recognition system-based follow-up), with reporting what was achieved a condition for receiving the funds in this 'budget line,' as well as continued funding to community-based practices and organizations that can provide post-discharge follow-up (and enhanced funding when communities experience gaps in the availability of counsellors and free or subsidized pharmacotherapy). To give a sense of the order of magnitude of counselling-related resources required, one dialogue participant noted that six counsellors were employed in hospitals in the Champlain Local Health Integration Network (and that these counsellors clearly 'influenced the bed-side behaviours of all professionals' with whom they came into contact). While one dialogue participant argued in favour of establishing who does what (and how many) before estimating resource requirements, and another dialogue participant identified the need for some type of benchmark (e.g., 1 FTE staff per 500 hospital beds), three dialogue participants warned against establishing a benchmark. Two of these three participants reasoned that the appropriate number of staff and the mix of FTE staff versus staff who take this on as part of their role should be highly context-specific, and a third opposed the idea of a benchmark due to the length of time its development would take, stating that 'if we wait for the ideal model we won't get anywhere.' One dialogue participant suggested that the 'budget line' should be scaled back after one-to-two years (i.e., once the one-time transition costs had been incurred), whereas another argued against scaling back given the needs for ongoing training, keeping up any momentum gained, and continuing integration efforts (given initial successes might take place in hospitals whereas longer-term successes will hinge on partnerships with primary healthcare teams, public health units and other community-based organizations). A third dialogue participant noted the importance of each hospital (or each sub-regional grouping of hospitals) allocating resources to prepare and keep updated an inventory of community resources available to support post-discharge follow-up. A fourth dialogue participant argued for resources to be dedicated to evaluation as well as to supporting a community of practice among those coordinating tobacco-use cessation support, so that they can learn from one another's experiences. A fifth dialogue participant argued that Tobacco Control Area Networks can play this support role, but another argued that this might not be the case given that hospital-based tobacco-cessation support is only one of their areas of focus.

A few dialogue participants noted that self-help materials are freely available through the Smokers' Helpline, which already has a mandate to work with hospitals, but one person noted that hospitals need to negotiate an

agreement with the Smokers' Helpline in order to access the materials in large volumes and to formalize the nature of their engagement in post-discharge follow-up.

One dialogue participant noted that in terms of patient incentives, the issue is more the removal of patient disincentives, such as costly pharmacotherapies.

No dialogue participants argued for changes to provider-payment mechanisms, although it was pointed out that the only primary healthcare physicians who receive targeted support for work in this area are those working in Aboriginal Health Access Centres, Community Health Centres and Family Health Teams.

**Question 4 – What are the indicators for success?**

As described previously, several dialogue participants noted the importance of measuring what is currently being done as a precursor to allocating resources to hospitals based on their local needs, and then establishing accountability agreements. These dialogue participants suggested that a key indicator would be the number (or proportion) of hospitalized patients (and/or hospital outpatients) who have been documented as tobacco users (both for each hospital as a whole and by specialty). In the words of one participant, 'this is something that can be done across the hospital, that is easy, and that helps the hospital' (by telling them how they're doing and whether to allocate additional resources) and the funders (by telling them where the need is and hence where to allocate resources).

One dialogue participant suggested that additional indicators could include the number (or proportion) of these tobacco users with at least one tobacco-use cessation support provided (or with each type of support, such as nicotine-replacement therapy, provided) and with at least one referral initiated (of any type or specifically to the Smokers' Helpline, which can easily be tracked but it just one example of a community support), as well as the number (or proportion) of hospital patients whose tobacco-use status has been documented. Another dialogue participant suggested that an additional indicator could include whether each hospital has an inventory of local community-based tobacco-use cessation supports to which referrals can be made (which presumably could be compiled by the individual charged with central coordination and operationalized as standard referral procedures). A third dialogue participant argued for including 'successful referrals' as an indicator, although the individual recognized that this would be difficult to operationalize. A fourth dialogue participant argued for including indicators related to fidelity to proven interventions, and a fifth argued for including indicators related to client satisfaction (as an approach rooted in the Institute for Healthcare Improvement's triple-aim approach would do). A sixth dialogue participant reminded the group that indicators need to be selected and used 'with an equity lens' (i.e., with a view to understand what's happening to specific groupings of patients, such as First Nations patients who intersect with health services funded by both the Ontario provincial government and the Canadian federal government, and not just what's happening on average). A seventh dialogue participant noted that such process indicators can be helpfully bundled together for hospital executives to use in hospital-accreditation processes. An eighth dialogue participant argued that indicator-development should be a task delegated to the proposed expert group given the complexities associated with articulating the purpose for the indicators (e.g., performance feedback, resource allocation and accountability), developing or selecting valid and reliable indicators, and defining success (e.g., doing as well as or better than at baseline or doing how much better than at baseline). However, a ninth dialogue participant cautioned the group, saying: 'Don't be so burdensome [with indicators] that people stop doing programs.'

Several dialogue participants disagreed with one another about whether outcome-related indicators in general (and quit rates at defined periods post-discharge in particular) should be used instead of or in addition to process-related indicators such as those described above. One individual argued that there are still significant knowledge gaps about which tobacco-use cessation supports are most effective in what contexts, and that such gaps could be addressed if outcome-related indicators were available, as well as that process-related

indicators are 'gameable' (i.e., individuals and organizations can make them look better than they actually are). A second individual argued that much is already known about expected quit rates with particular cessation supports (and in what 'doses' and settings), that long-term follow-up is not hospitals' role, and that targeted monitoring and evaluation systems (such as the one established by individuals in Ottawa) and dedicated research studies are more appropriate ways to examine effectiveness. A third dialogue participant noted that many factors outside of hospitals' control influence quit rates, and that it would be discouraging to hospitals to use such an indicator given how low it typically is. A fourth dialogue participant concluded that indicators simply need to capture leading practices (and nothing more).

Dialogue participants noted that data about screening for and prevalence of tobacco use could be captured through the electronic admitting (or registration) record, whereas the provision of supports and making of referrals could be captured through patient charts. One dialogue participant noted that an interactive voice-recognition system is being used efficiently in a number of sites in Ontario to collect follow-up data from patients (as a replacement for a central coordinator doing such work at an average of 500-600 patient follow-ups per year). A second dialogue participant suggested that for indicators to be truly helpful they needed to be available in real time, while a third argued that indicator data should be collected in a centralized provincial database. A fourth dialogue participant noted that tobacco use is already being captured for patients with an acute myocardial infarction (i.e., heart attack) in the Ottawa area, and made available through the Canadian Institute for Health Information. The same individual emphasized the importance of being able to present indicator data by specialty (e.g., cardiac care, obstetrics). A fifth dialogue participant argued that efforts should be made to identify the contribution that tobacco-use cessation makes to indicators that have already been prioritized, such as hospital re-admission rates. In response to this suggestion, another dialogue participant noted that it can be helpful to create a logic model that clearly identifies which elements of a comprehensive approach to hospital-based tobacco cessation affect which indicators.

One dialogue participant noted that data at the unit level could be fed back to hospital staff through in-service training, whereas data at the hospital level could be fed back to hospital administrators through reports from a central coordinator and to Local Health Integration Networks through a report required as part of an accountability agreement. One dialogue participant argued in favour of public reporting as part of a virtuous cycle of measurement, resourcing and accountability.

### Question 5 – What reminder systems are needed to ensure this is done?

A number of dialogue participants argued for the importance of establishing reminder systems in order to prompt healthcare professionals to provide supports. Such systems can range from more 'manual' systems (e.g., having tobacco-intervention forms being a part of patients' charts and providing feedback about the provision of these interventions based on an analysis of these forms) to more automated systems as electronic health records become commonplace (targeted at individual providers, units and organizations, as well as patients themselves in terms of documenting their tobacco use and receipt of tobacco-use cessation supports through voice-recognition systems, among others). One dialogue participant noted that 'we got nowhere without [reminders]' but 'they have to be simple' if they're going to be a 'job aid.' Another noted that their hospital supplements the reminders that are part of the care path with posters targeted at both providers and patients. A third dialogue participant suggested that reminders had to be 'built into the system, especially if there's an electronic health record.' A fourth dialogue participant argued in favour of any form of 'routinization,' whether this means kardexes, electronic health records or anything else.

### Question 6 – Who do you hold accountable to do this?

Dialogue participants noted that there were many types of accountabilities, including accountabilities at the professional level (such as the one that has been informally established for registered nurses through the RNAO best practice guideline and the one that has been formally established for admitting and central

coordination staff in all hospitals in northwestern Ontario) and at the organizational level (such as the one that has been informally established by some hospital CEOs and boards of directors, including those that include their tobacco-use cessation support efforts in their reports to Accreditation Canada, and the ones that have been formally established for hospitals in the Ottawa region by the Champlain Local Health Integration Network), as well as accountabilities for efforts undertaken within hospitals (which was the primary focus of the deliberation) and for post-discharge follow-up in the community (which was acknowledged as a big challenge).

Several dialogue participants argued in favour of identifying existing accountability arrangements that offered an 'entry point' for tobacco-use cessation support, such as health professionals' practices being judged against the standards of their peers (which could be interpreted as the standard established in 'best practice guidelines'), hospital CEOs' salaries being tied to their performance, hospitals' re-admission rates being examined as part of Local Health Integration Network accountability agreements, hospitals' employment practices being governed by occupational health and safety legislation, and hospitals' spending on health promotion and disease prevention being examined by disease-focused associations in relation to a proposed target of 0.5% of hospital budgets.

**Considering the full array of initiative elements**

One dialogue participant noted that very little had been said about patients and that they had a key role to play in self-management, contributing data (e.g., through voice-recognition systems) and providing feedback about tobacco-use cessation supports (e.g., through client-satisfaction surveys).

Several dialogue participants mentioned the possibility of developing a business case for hospital-based tobacco-use cessation support or at least elements of it. One dialogue participant introduced the idea that the aforementioned expert group could, in addition to their core tasks, describe the costs of inaction as well as the timeframe over which different types of benefits would accrue (e.g., fewer hospital re-admissions and fewer primary healthcare visits for tobacco-related illnesses). Another dialogue participant suggested that the timeframe is of the order of five years. A third dialogue participant cautioned against spending too much time on a return-on-investment analysis given that the Ontario provincial government also accrues significant tax revenues from tobacco sales, and that Ontario hospitals aren't necessarily the organizations that accrue the benefits arising from their tobacco-use cessation initiatives.

Dialogue participants disagreed about the importance of situating hospital-based tobacco-use cessation support within the context of broader integration efforts. Some saw integration between hospitals, community-based clinics and public health units, and integration between tobacco-use cessation programs and the broad array of chronic disease prevention and treatments programs, as being essential to success both in tobacco-use cessation and in other domains, whereas others expressed concern that 'trying to do everything will mean we accomplish nothing.' In arguing for the former, one individual asked 'what's our system model?' and noted that, even though the 'spotlight is on hospitals now, we need to take action in other' sectors simultaneously. In arguing for the latter, another individual pointed out that the Ontario Ministry of Health and Long-Term Care has already appointed a 'cessation task force' that will enable at least part of any broader focus on integration (across sectors dealing with tobacco-use cessation as well as tobacco-related prevention and protection). One dialogue participant suggested that this broader view should encompass health professional education, given so many professional practices adopted during training become lifelong practices. Another dialogue participant suggested that this broader view should also encompass bolder initiatives like hospitals not hiring smokers and not accepting frequent tobacco use-related absences from their posts, and associated productivity shortfalls.

## DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Given that many of the six questions dealt explicitly with implementation considerations, dialogue participants did not engage in dedicated deliberation on this topic. Instead, the group moved directly to a discussion about next steps for different constituencies.

## DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

A number of dialogue participants argued that one key set of next steps – the development of a performance-management model to support organizational change – would ideally come in a sequenced way from the Ontario Ministry of Health and Long-Term Care, which could:
1) issue a directive about the need to develop a small set of indicators that would be tracked across all Ontario hospitals;
2) request Local Health Integration Networks to add to hospital global budgets a budget line that provides the necessary resources for each hospital to provide the tobacco-use cessation supports that indicators suggest there is a need for; and
3) request Local Health Integration Networks to add to accountability agreements with hospitals what is expected in return for these dedicated funds (as well as add to accountability agreements with community-based clinics what is expected of them).

Dialogue participants also argued that a complementary set of next steps could be taken by Health Quality Ontario, which could:
1) jump-start action immediately by establishing an expert panel to rapidly describe incremental or scalable enhancements (or packages of or options for enhancements) that can be flexibly introduced by each Ontario hospital as it moves from its current practices to leading practices, as well as the indicators that can be used to measure progress; and
2) use its own resources to support the system-wide roll-out of these enhancements while it simultaneously supports the Ontario Ministry of Health and Long-Term Care and Local Health Integration Networks to 'institutionalize' these enhancements (as described above).

A few dialogue participants also noted the potential contributions of other organizations, such as:
1) Accreditation Canada, which could include tobacco-use cessation support within its accreditation framework (although one dialogue participant cautioned that this 'could take up to 10 years');
2) Canadian Institute for Health Information, which could include indicators related to tobacco use and tobacco-use cessation support in its datasets;
3) Cancer Care Ontario, which is already planning an initiative in this domain and, through its long history of using a sequenced combination of measurement, resourcing and a combination of accountability agreements and public reporting to support system-wide roll-outs, could provide a template for many hospitals to follow;
4) Ontario Hospital Association, which could identify champions among its CEO members who could encourage their peers to move beyond 'ignorance and indifference'; and
5) professional associations and regulatory colleges, which could identify champions among their professional members who could encourage their peers to do the same.

One dialogue participant cautioned the group that tackling all of these domains could result in inertia and duplication, while a second dialogue participant cautioned the group that directives could disrupt existing initiatives. Both dialogue participants emphasized the importance of a focused effort to leverage the good work already being done in Ontario.